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5 IN THE UNITED STATES DISTRICT COURT  
6  
7 FOR THE NORTHERN DISTRICT OF CALIFORNIA

8 AIMEE SHEMANO-KRUPP,

9 Plaintiff,

No. C 05-04693 JSW

10 v.

11 MUTUAL OF OMAHA INSURANCE  
12 COMPANY, et al.,

13 Defendants.  
14 \_\_\_\_\_/

**ORDER DENYING DEFENDANT  
BENARDS' MOTION FOR  
SUMMARY JUDGMENT**

15 Now before the Court is the motion for summary judgment or, in the alternative, for  
16 partial summary judgment filed by Defendant Rodger L. Benard ("Benard"). Having carefully  
17 reviewed the parties' papers and the relevant legal authority, and having had the benefit of oral  
18 argument, the Court hereby denies Benard's motion for summary judgment.<sup>1</sup>

19 **BACKGROUND**

20 Plaintiff Aimee Shemano-Krupp ("Plaintiff") brought this action against defendants  
21 United of Omaha Life Insurance Company ("United") and Mutual of Omaha Insurance  
22 Company ("Mutual") to obtain life insurance benefits under an employee benefit plan  
23 purportedly covering her father, Richard Shemano ("Mr. Shemano"), a stockbroker for The  
24 Shemano Group ("TSG"). Benard was Mr. Shemano's insurance agent and the agent for TSG  
25 with respect to obtaining the insurance policy at issue and advised Mr. Shemano with respect to  
26 the scope and content of the policy. Plaintiff is bringing claims against Benard for professional  
27 negligence, negligent misrepresentation, and breach of fiduciary duty.  
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<sup>1</sup> Benard's request for judicial notice ("RJN") is granted. *See* Fed. R. Evid. 201.

1 The Plan is governed by the Employee Retirement Income Security Act (“ERISA”), 29  
2 U.S.C. § 1001 *et seq.* United issued the subject group Life and Accidental Death and  
3 Dismemberment Policy, Policy No. GLUG-32N5, effective May 1, 1998 (the “Policy”).  
4 (*See* Declaration of Diane Quinones in Support of United and Mutual’s Motion for Summary  
5 Judgment (“Quinones Decl.”), ¶ 4, Ex. A at 0001-0044.)

6 Under the Plan, a \$200,000 death benefit is payable in the event of death of an eligible  
7 employee who under the age of 65. (*Id.* at 0026.) The Plan has specific eligibility provisions  
8 and defines an eligible employee as a “regular, full-time employee; ... actively employed; and ...  
9 receiv[ing] compensation for [their] work.” (*Id.* at 0018). Active employment is further  
10 defined as “working 30 hours or more a week at [one’s] regular job; and customary place of  
11 employment.” (*Id.*) The policy further provides that the insurance coverage will end when the  
12 employee does not satisfy “the requirements for hours worked; or any other eligibility condition  
13 in the policy.” (*Id.* at 0020.) The same provision also states that “upon uninterrupted payment  
14 of premium to [the Insurer, the Insured] may be eligible to continue coverage in accord with the  
15 following continuation provision.” (*Id.*) Subject to the uninterrupted payment of premium, the  
16 policy provides for a limited continuation of life insurance coverage for eligible employees who  
17 are no longer defined as actively employed due to total disability. In that circumstance, the life  
18 coverage automatically continues for twelve months starting from the date the insured first  
19 became totally disabled. However, the policy continues, the 12-month period is extended  
20 thereafter, without premium payments, subject to certain conditions. (*Id.* at 0021.) Those  
21 required conditions are that the disability began while the employee was insured under the  
22 policy, the disability began before the employee reached the age of 60, and the employee has  
23 completed the 12-month disability elimination period. (*Id.*) For disabled employees who  
24 became disabled over the age of 60, the policy permits eligible employees the option of  
25 converting to an individual life insurance policy within 31 days of the date their eligibility ends  
26 (12-months plus 31 days). (*Id.*)

27 According to the long-term disability claim form submitted on behalf of Mr. Shemano  
28 by his employer, TSG, on April 19, 2002, Mr. Shemano ceased to work due to the increasing ill

1 effects of lung cancer and a brain tumor. (*Id.* at 0081.) Mr. Shemano also provided a  
2 Physician's Statement with his claim which was signed on July 24, 2002 by his doctor and  
3 indicated that Mr. Shemano was likely to be permanently disabled and also indicated at the time  
4 of his visit in July 9, 2002, the doctor believed that his patient had not worked since April 2002.  
5 (*Id.* at 0087-88.) At the time Mr Shemano ceased working he was 61 years old. By letter dated  
6 September 19, 2002, United approved Mr. Shemano's total disability claim and began paying  
7 benefits. (*Id.* at 0067.)

8 Although United assessed Mr. Shemano's condition to be severe and likely terminal and  
9 did not require regular confirmation of his disability, on August 27, 2003, Mrs. Shemano on her  
10 husband's behalf, submitted a Supplementary Report of Disability in which she indicated that  
11 her husband had been totally disabled from April or May of 2002 until the date of her report in  
12 August 2003. (*Id.* at 0069.) Mrs. Shemano also indicated that Mr. Shemano had been  
13 hospitalized from June 26 until July 27, 2003, he was in hospice care and his daily activities  
14 were limited to "total bed rest." (*Id.*) Mr. Shemano's physician submitted a supplemental  
15 report on August 29, 2003 in which the doctor indicated that Mr. Shemano had been  
16 hospitalized and was thereafter admitted to hospice care. (*Id.* at 0070.) Mr. Shemano remained  
17 in home hospice care until the date of his death, on December 8, 2003. (*Id.* at 0459.) He was  
18 62 years old. Mr. Shemano received long-term disability benefits from United from July 21,  
19 2002 until the time of his death.

20 In addition to receiving disability benefits from United, Mr. Shemano applied for and  
21 received disability benefits from the Social Security Administration, as well as the California  
22 State Disability program. (*Id.* at 0072-74.)

23 On December 31, 2003, Plaintiff submitted a Proof of Death claim form and death  
24 certificate. (Quinones Decl., Ex. A at 0457-59.) United responded to TSG on January 5, 2004  
25 and requested information regarding the last day of active work for Mr. Shemano. (*Id.* at 0451.)  
26 On January 23, 2004, United spoke with the selling agent, Benard, who indicated that he  
27 believed Mr. Shemano last worked in June 2003. (*Id.* at 00445.) United also spoke with the  
28 Chief Operating Officer of TSG, Mike McDonough, who indicated that Mr. Shemano had last

1 worked in April 2002. (*Id.* at 0444-45.) In a subsequent conversation two days later, Mr.  
2 McDonough reversed himself and indicated that Mr. Shemano had indeed returned to work  
3 approximately two to four months after April 2002 and had been working just enough to cover  
4 the premiums for coverage until June 2003. (*Id.* at 0443.) Mr. McDonough also indicated that  
5 TSG did not keep any record of the hours Mr. Shemano worked and did not explain how he  
6 could have worked only to cover the cost of the premiums which were paid instead by the  
7 employer. (*Id.*, Quinones Decl., ¶ 8.) On January 29, 2004, Mr. McDonough faxed a letter to  
8 United which indicated that Mr. Shemano had returned to work in June 2002 and ceased  
9 working in June 2003, had periodic absences due to his treatment, and received “no monetary  
10 compensation during the period between April 2002 and June 2003 because no commissions  
11 were earned.” (*Id.* at 0442.) There was no contemporaneous documentation indicating the  
12 actual days or hours Mr. Shemano had worked during this period. United’s consulting  
13 physician examined the medical information in Mr. Shemano’s claim file and reported there  
14 was no documentation indicating that Mr. Shemano could not work during the time period.

15       Based on the contemporaneous disability claim file records submitted to United by TSG  
16 on Mr. Shemano’s behalf, by his wife and his physician, as well as submitted to the Social  
17 Security Administration and the State of California, United denied Plaintiff benefits by letter  
18 dated February 10, 2004. (*Id.* at 0431-32.) The letter explained the applicable policy  
19 provisions and noted that the records indicated that Mr. Shemano had last worked in April 2002  
20 and had remained off work due to total disability until his death. It noted that although the  
21 employer had advised that Mr. Shemano returned to the office, he did not receive compensation  
22 and did not qualify as actively employed during the relevant time period. The letter explained,  
23 without reference to specific policy provisions by number, that without remaining actively  
24 employed, Mr. Shemano’s coverage only continued for a period of 12 months and did not  
25 automatically continue as he was over the age of 60 at the time of onset of total disability. The  
26 letter further explained that Plaintiff could appeal the decision. (*Id.*)

27       On February 27, 2004, Mr. McDonough of TSG appealed the decision by United to  
28 deny payment of benefits. (*Id.* at 0419.) The letter indicated that Mr. Shemano had returned to

1 work in June 2002 and had worked until December 2003, the month of his death. (*Id.*) The  
2 letter stated that he did not receive payment during this period because, as a commissioned sales  
3 person, Mr. Shemano only earned enough to cover his employee-paid benefits which were paid  
4 on his behalf in lieu of a paycheck. United evaluated the new material and, by internal  
5 memorandum, assessed that the new work dates contradicted the information contained in the  
6 long-term disability claim records to United as well as the Social Security Administration and  
7 the State of California. (*Id.* at 0418.)

8 On March 26, 2004, United wrote a letter to Plaintiff affirming its decision to deny  
9 benefits. (*Id.* at 0413-15.) The denial explained the same reasoning for United's decision, cited  
10 a supplemental report from another treating physician and noted the absence of any records  
11 from TSG which would document the company's position that Mr. Shemano returned to active  
12 employment during the period June 2002 through June 2003. (*Id.*) United also advised Plaintiff  
13 that the company would consider any additional information it received within 90 days. (*Id.* at  
14 415.)

15 On May 17, 2004, United received a call from Mr. Benard in which he stated his belief  
16 that Mr. Shemano continued to work through June 2003. (*Id.* at 0393-94.) United continued to  
17 maintain the position that it would review the claim if TSG produced contemporaneous  
18 documents indicating Mr. Shemano had returned to active employment, such as time cards,  
19 records of trade transactions, commission statement, W-2 forms, or the like. (*Id.*)

20 Approximately three months later, United received a letter from Plaintiff's attorney with four  
21 letters signed by TSG employees who stated that they had observed Mr. Shemano return to  
22 service clients during the disputed time period. (*Id.* at 0384-391.) By letter dated August 26,  
23 2004, United responded to Plaintiff's attorney and advised him that the information received  
24 was inadequate to alter the denial decision because United deemed them not credible  
25 considering the lack of objective documentation to support the contention of continued  
26 employment and compensation. (*Id.* at 0379-381.) The letter further indicated that there was  
27 no evidence to explain the contradiction between the recently-submitted letters and the  
28 contemporaneous assertions made by Mr. Shemano, his employer and his wife to the insurance

1 company, the State of California and the Social Security Administration as well as his treating  
2 physicians that he was not able to work and was therefore qualified to receive disability  
3 payments from each of those sources. (*Id.* at 0379.) Again, the letter indicated the decision was  
4 a final determination of the appeal, but that United would consider any new information within  
5 30 days. (*Id.* at 0380.)

6 The Court granted United and Mutual's motion for summary judgment, finding: (1) the  
7 insurance policy at issue is subject to and governed by ERISA; (2) Plaintiff's state-law claims  
8 against United and Mutual are fully preempted; and (3) pursuant to an abuse of discretion  
9 standard, there was substantial evidence to sustain United's denial of coverage. Benard now  
10 moves for summary judgment on Plaintiff's claims against him, arguing that Plaintiff's state-  
11 law claims are preempted by ERISA and that, even if they are not preempted, they fail as a  
12 matter of law.

### 13 ANALYSIS

#### 14 A. Summary Judgment Standard.

15 Summary judgment is proper when the "pleadings, depositions, answers to  
16 interrogatories, and admissions on file, together with the affidavits, if any, show that there is no  
17 genuine issue as to any material fact and that the moving party is entitled to judgment as a  
18 matter of law." Fed. R. Civ. P. 56(c). An issue is "genuine" only if there is sufficient evidence  
19 for a reasonable fact finder to find for the non-moving party. *Anderson v. Liberty Lobby, Inc.*,  
20 477 U.S. 242, 248-49 (1986). A fact is "material" if the fact may affect the outcome of the case.  
21 *Id.* at 248. "In considering a motion for summary judgment, the court may not weigh the  
22 evidence or make credibility determinations, and is required to draw all inferences in a light  
23 most favorable to the non-moving party." *Freeman v. Arpaio*, 125 F.3d 732, 735 (9th Cir.  
24 1997). A principal purpose of the summary judgment procedure is to identify and dispose of  
25 factually unsupported claims. *Celotex Corp. v. Cattrett*, 477 U.S. 317, 323-24 (1986). The  
26 party moving for summary judgment bears the initial burden of identifying those portions of the  
27 pleadings, discovery, and affidavits which demonstrate the absence of a genuine issue of  
28 material fact. *Id.* at 323. Where the moving party will have the burden of proof on an issue at

trial, it must affirmatively demonstrate that no reasonable trier of fact could find other than for the moving party. *Id.* Once the moving party meets this initial burden, the non-moving party must go beyond the pleadings and by its own evidence “set forth specific facts showing that there is a genuine issue for trial.” Fed. R. Civ. P. 56(e). The non-moving party must “identify with reasonable particularity the evidence that precludes summary judgment.” *Keenan v. Allan*, 91 F.3d 1275, 1279 (9th Cir. 1996) (quoting *Richards v. Combined Ins. Co.*, 55 F.3d 247, 251 (7th Cir. 1995)) (stating that it is not a district court’s task to “scour the record in search of a genuine issue of triable fact”). If the non-moving party fails to make this showing, the moving party is entitled to judgment as a matter of law. *Celotex*, 477 U.S. at 323.

**B. ERISA Preemption.**

Plaintiff asserts state-law causes of action against Benard for professional negligence, negligent misrepresentation, and breach of fiduciary duty. Whether ERISA acts to preempt a state or local law is a question of law. *Farr v. U.S. West Communications, Inc.*, 151 F.3d 908, 913 (9th Cir. 1998). Section 514(a) provides that ERISA “supercede[s] any and all State laws insofar as they now or hereafter relate to any employee benefits plan.” 29 U.S.C. § 1144(a). State laws are preempted by ERISA “insofar as they may now or hereafter relate to any employee benefit plan” regulated by ERISA. 29 U.S.C. § 1144(a).

The language of ERISA’s preemption provision – covering all laws that relate to an ERISA plan – is clearly expansive. *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 655 (1995). A state law relates to an ERISA employee benefit plan “if it has a connection with or reference to such a plan.” *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 97 (1983). “The ERISA preemptive provision is to be broadly construed and extends to common law tort and contract actions.” *Gibson v. Prudential Ins. Co. of America*, 915 F.2d 414, 416 (9th Cir. 1990).

Although the text of the ERISA preemption provision is clearly expansive, courts have recognized that the term “relate to” cannot be “taken to extend to the furthest stretch of its indeterminacy,” or else “for all practical purposes preemption would never run its course.” *Travelers*, 514 U.S. at 655. Indeed, “applying the ‘relate to’ provision according to its terms

1 was a project doomed to failure, since, as many a curbstome philosopher has observed,  
2 everything is related to everything else.” *California Division of Labor Standards Enforcement*  
3 *v. Dillingham Construction*, 519 U.S. 316, 335 (1997). “Some state actions may affect  
4 employee benefit plans in too tenuous, remote or peripheral a manner to warrant a finding that  
5 the law ‘relates to’ the plan.” *Shaw*, 463 U.S. at 100 n.21; *Aloha Airlines*, 12 F.3d at 1504.  
6 Accordingly, the Court cannot rely on “uncritical literalism” but must rather attempt to ascertain  
7 whether Congress would have expected the particular statute at issue to be preempted.  
8 *Travelers*, 514 U.S. at 656.

9       However, “before a court wades into this provision’s ‘veritable Sargasso Sea of  
10 obfuscation,’ it must first resolve the simpler question of whether a party may assert a claim  
11 under ERISA.” *Miller v. Rite Aid Corp.*, 504 F.3d 1102, 1105 (9th Cir. 2007) (citing *Toumajian*  
12 *v. Frailey*, 135 F.3d 648, 653 n.3 (9th Cir.1998) (citation and internal quotation marks  
13 omitted)). “ERISA does not preempt the claims of parties who do not have the right to sue  
14 under ERISA because they are neither participants in nor beneficiaries of an ERISA plan.”  
15 *Miller*, 504 F.3d at 1106. Plaintiff may sue under ERISA only if Mr. Shemano was a  
16 “participant” in an ERISA plan “at the relevant time,” or if he may have become eligible for  
17 benefits from an ERISA plan “at such time.” *Id.* In order to establish that Mr. Shemano “may  
18 have become eligible,” Plaintiff “must have a colorable claim that (1) [she] will prevail in a suit  
19 for benefits, or that (2) eligibility requirements will be fulfilled in the future.” *Id.* (quoting  
20 *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 117 (1989)).

21       The Ninth Circuit held in *Miller* that the applicable time for evaluating the claims of a  
22 decedent’s estate and beneficiaries is the time of death. *Id.* at 1107. Benard argues that the  
23 holding of *Miller* is not so narrow and that the “relevant time” here is when the alleged  
24 misconduct occurred. Another court has already considered and rejected this argument. *See*  
25 *Widdows v. Fred Meyer, Inc.*, 2008 WL 3992149, \* 9-10 (D.Or. Aug. 22, 2008) (finding that  
26 under *Miller*, the “relevant time” was time of death, not the time of the alleged misconduct).  
27 The Court finds the reasoning of *Widdows* persuasive and agrees that the holding of *Miller* is  
28 that the “relevant time” for evaluating Plaintiff’s claims is the time of Mr. Shemano’s death.

1 The parties do not dispute that at the time of Mr. Shemano's death, he was not a  
2 participant in an ERISA plan. In his reply brief, Benard argues that Plaintiff has a colorable  
3 claim for benefits because Plaintiff has maintained in this lawsuit that she has a colorable claim  
4 for death benefits because Mr. Shemano continued to work at least thirty hours a week until  
5 June of 2003. (Reply at 4-5.) As the Court previously found:

6 Because Mr. Shemano was over 60 years of age at the time of the onset of his  
7 disability, he was, subject to the unambiguous terms of the policy, entitled to 12  
8 months of continued coverage, at which point the policy was terminated unless he  
9 converted to an individual policy. The exception, clearly set out in the policy  
language, provided that should the insured return to work as an active full-time  
employee receiving compensation, the period of disability would start over again.

10 (Docket No. 73 at 15-16.)

11 The Court has already reviewed the evidence presented by the parties on this issue and  
12 determined that "[a]lthough there is some non-contemporaneous evidence that Mr. Shemano  
13 may have come into the office at various times to talk with his clients on the telephone, there is  
14 no evidence that he was working full-time at his regular job and receiving compensation."  
15 (Docket No. 73 at 16.) Accordingly, the Court finds that Plaintiff does not have a colorable  
16 claim for benefits under ERISA. Because Plaintiff does not have standing under ERISA to  
17 bring a claim, ERISA does not preempt her state-law claims. *Miller*, 504 F.3d at 1106.

18 **C. Plaintiff's State-Law Claims.**

19 **1. Professional Negligence.**

20 Benard moves for summary judgment on Plaintiff's claim for professional negligence on  
21 the grounds that Benard did not owe any duty to Mr. Shemano to advise him regarding the life  
22 insurance policy provisions and that Benard did not breach any duty to the extent any existed.  
23 As with any negligence claim, Plaintiff "must show that the defendant had a duty to use due  
24 care, that he breached that duty, and that the breach was a proximate or legal cause of the  
25 resulting injury." *Rice v. CenterPoint, Inc.*, 154 Cal. App. 4th 949, 955 (2007) (citation  
26 omitted). The existence of a duty is a question of law to be decided by the court. *Hansara v.*  
27 *Superior Court*, 7 Cal. App. 4th 630, 639 (1992).

1 “Ordinarily, an insurance agent assumes only those duties normally found in any agency  
2 relationship. This includes the obligation to use reasonable care, diligence, and judgment in  
3 procuring the insurance requested by an insured.” *Jones v. Grewe*, 189 Cal. App. 3d 950, 954  
4 (1987). In *Jones*, the court reiterated the standard set forth in an earlier case that an agent owes  
5 a duty to explain the provisions of an insurance policy in response to inquiries regarding  
6 coverage. *Id.* at 955 (citing *Westrick v. State Farm Ins.*, 137 Cal. App. 3d 685, 692 (1982)).  
7 Contrary the Benard’s broad assertions, the court in *Jones* merely held that “[t]he general duty  
8 of reasonable care which an insurance agent owes his client does not include the obligation to  
9 procure a policy affording the client complete liability protection ... .” *Id.* at 956.

10 *Malcom v. Farmers New World Life Ins. Co.*, 4 Cal. App. 4th 296 (1992) does not assist  
11 Benard either. In *Malcom*, the court held that an applicant’s question about what effect his  
12 treatment for depression might have on his application did not impose an affirmative duty on  
13 the insurance agent to advise him regarding the suicide provision and its effect on coverage. *Id.*  
14 at 304. The court found that there was no evidence which suggested that the agent knew the  
15 applicant procured the insurance policy under the mistaken belief that the policy would cover  
16 all suicide-related death. *Id.*

17 Here, there is evidence in the record sufficient to create a question of fact regarding  
18 whether Mr. Shemano asked Benard, in the context of his being diagnosed with brain and lung  
19 cancer and having had recent brain surgery, about how to maintain his life insurance coverage.  
20 (Declaration of Terrance J. Coleman (“Coleman Decl.”), Ex. A at 78:12-22, 83:23-85:25.)  
21 Benard responded by telling Mr. Shemano that he only had to worry about converting his life  
22 insurance from a group to an individual policy if he left his employer. (*Id.*) However, the  
23 insurance policy only provides the \$200,000 death benefit for active full-time employees  
24 receiving regular compensation. (Quinones Decl., Ex. A.) In light of the record before it, the  
25 Court cannot conclude as a matter of law that Benard did not have a duty to advise Mr.  
26 Shemano regarding maintaining his life insurance coverage and that Benard did not breach such  
27 duty. Accordingly, the Court denies Benard’s motion for summary judgment on Plaintiff’s  
28 claim for professional negligence.

1           **2.       Negligent Misrepresentation.**

2           To establish her claim for negligent misrepresentation, Plaintiff must demonstrate: “(1) a  
3 misrepresentation of a past or existing material fact, (2) without reasonable grounds for  
4 believing it to be true, (3) with intent to induce another’s reliance on the fact misrepresented, (4)  
5 ignorance of the truth and justifiable reliance thereon by the party to whom the  
6 misrepresentation was directed, and (5) damages.” *Fox v. Pollack*, 181 Cal. App. 3d 954, 962  
7 (1986). Benard argues that he did not make any misrepresentations because he did not discuss  
8 life insurance coverage under the insurance plan with Mr. Shemano after he was diagnosed with  
9 brain and lung cancer. As discussed above, the Court finds that there is a question of fact which  
10 precludes summary judgment on this ground. Next, Benard argues that he reasonably believed  
11 Mr. Shemano was covered under the insurance policy, which required that Mr. Shemano was an  
12 active full-time employee receiving regular compensation, until June of 2003. Again, the Court  
13 finds that there are questions of fact which preclude summary judgment. Therefore, the Court  
14 denies Benard’s motion for summary judgment on Plaintiff’s claim for negligent  
15 misrepresentation.

16           **3.       Fiduciary Duty.**

17           Benard argues that as a matter of law, an insurance broker cannot be held liable for  
18 breach of fiduciary duty. However, the authority upon which Benard relies does not stand for  
19 this proposition. In *Hydro-Mill Co. v. Hayward, Tilton, and Rolapp Ins. Associates Inc.*, 115  
20 Cal. App. 4th 1145, 1156 (2004), the court held that because a complaint against an insurance  
21 broker demonstrated that allegations of professional negligence subsumed all of the allegations  
22 for breach of fiduciary duty, the complaint was barred by a two-year statute of limitations. In  
23 reaching its conclusion, however, the court noted that “it is unclear whether a fiduciary  
24 relationship exists between an insurance broker and an insured.” *Id.* Similarly, the court in  
25 *Jones v. Grewe*, 189 Cal. App. 3d 950 (1987) did not hold as a matter of law that insurance  
26 brokers never owe a fiduciary duty to their clients. The Court notes that in *Steadman v.*  
27 *McConnell*, 149 Cal. App. 2d 334, 338 (1957), the court held that where an insurance agent was  
28 an expert in the field and the insured was a layman, there was a fiduciary relationship between

1 the insurance agent and the insured. Therefore, the Court cannot find that as a matter of law,  
2 Bernard did not owe a fiduciary duty to Mr. Shemano, and thus, denies Benard's motion for  
3 summary judgment on Plaintiff's claim for breach of fiduciary duty.

4 **CONCLUSION**

5 For the foregoing reasons, the Court DENIES Benard's motion for summary judgment.

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7 **IT IS SO ORDERED.**

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9 Dated: September 15, 2008

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12 JEFFREYS. WHITE  
13 UNITED STATES DISTRICT JUDGE  
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